President's Management Council
INTERAGENCY ROTATION PROGRAM

The PMC Interagency Rotation Program enables emerging Federal leaders to expand their leadership competencies, broaden their organizational experiences, and foster networks they can leverage in the future.

Employee Statement of Interest

TO BE COMPLETED BY POTENTIAL ROTATIONS PROGRAM PARTICIPANT:

Name:	Click here to enter text.		
Department/Agency:	Click here to enter text.		
Component:	Click here to enter text.	**Functional Area:**	Click here to enter text.
Email Address:	Click here to enter text.	**Phone Number:**	Click here to enter text.
Current Title:	Click here to enter text.	**Current Clearances:**	Click here to enter text.
GS Level:	Click here to enter text.	**Location/Address:**	Click here to enter text.
Supervisor Name:	Click here to enter text.	**Supervisor Email:**	Click here to enter text.
Supervisor Title:	Click here to enter text.	**Supervisor Phone:**	Click here to enter text.

Brief Description of Current Role (major/core duties):

Click here to enter text.

Brief Bio/Description of Professional Background:

Click here to enter text.

Developmental Goals: Please identify 2-3 Executive Core Qualification (ECQ) Competencies you aim to develop and provide additional input. For more information about the ECQ Competencies, please visit: www.opm.gov/ses/recruitment/ecq.asp.

ECQs (check all that apply):		*Please provide comments on your developmental goals related to this assignment:*
Leading Change	☐	Click here to enter text.
Leading People	☐	
Results Driven	☐	
Business Acumen	☐	
Building Coalitions	☐	

Please provide information about your career objectives and the steps you have taken to work toward them:

Click here to enter text.

How would this opportunity contribute to your short-term performance and long-term career goals?

Click here to enter text.

Special Requirements (if any):

Click here to enter text.

I understand this program's requirements and am prepared to engage in a 6-month rotation at another agency:

Click here to enter a date.

_____   _____
Employee's Signature   **Date**

Supervisor Approval

TO BE COMPLETED BY SUPERVISOR:

Employee strengths:
Click here to enter text.

Employee career development needs:
Click here to enter text.

Based on this individual's strengths and development needs, what type of work might be most beneficial? (For example, a project focused on a technical area, a leadership competency, a function/process, etc.) Why?
Click here to enter text.

	YES	NO
I support this individual's interest in this program:	☐	☐
I recommend this individual for this program:	☐	☐
This person is available for a 6-month interagency rotation:	☐	☐

_____

Supervisor's Signature

Click here to enter a date.

Date

TO BE COMPLETED BY COMPONENT MANAGEMENT (DEPUTY ASSISTANT SECRETARY or EQUIVALENT):

	YES	NO
I support this employee's participation in a 6-month interagency rotation:	☐	☐

Comments (optional):
Click here to enter text.

_____

Deputy Assistant Secretary or Equivalent Signature

Click here to enter a date.

Date